

# Comments on CMMI Application

Complex Care  
Committee

March 22, 2013

# Written Comments as of 03/22/2013

Name	Organization
Robert Smanik	Day Kimball Healthcare
Quincy Abbot	Advocate
Claudio Gualtieri	AARP
Jill Benson LCSW	CHR Health
Matt Katz	CSMS
Molly Rees Gavin	CT Community Care
Marie Smith, PharmD	UConn Pharmacy
Olivia Puckett	CGA
Steering Committee	Complex Care Committee
Sheldon Toubman	New Haven Legal Assistance

# Robert Smanik

**From:** Smanik, Robert [<mailto:RSmanik@DayKimball.org>]

**Sent:** Wednesday, March 20, 2013 9:53 AM

**To:** Weiser, Rebecca (Rivka)

**Subject:** RE: Draft Application for Demo Implementation Funding - Complex Care Committee [not-secure]

Rivka

I continue to be impressed with the work done by all associated with this effort. The breadth and depth of the planning is truly remarkable. I believe this effort can produce a much better system of care for our communities.

My request for consideration is that a statement be added to the proposal that would recognize local efforts to provide components of service delivery without such services being required to come from your core state wide organizations identified throughout the proposal. Past experience has shown that until we bring supports and accountability to the provider level the ability to impact behavior change is limited. I acknowledge that such a bold undertaking as described in this proposal needs to have consistency and accountability for DSS. However I would like to see the option for replacing the middle organizations and thus avoiding duplication as soon as such efforts can be recognized and verified and thus not be prohibited by the exclusivity implied in this report.

Thank you for considering my request. I remain very supportive of your efforts.

Bob Smanik

Day Kimball Healthcare

# Quincy Abbot:

Kate and Sheila,

On this morning's conference call I mentioned my concern that the MFP Grant and the MME Grant be coordinated and integrated as far as possible. This is especially true for those MME's who transition from an institution to the community. Any conflict would be at least confusing to the individual and perhaps harmful. I believe Kate said that the coordination or integration would be dealt with in the operational plan. Some specific concerns are:

- A MFP Transition Coordinator has a similar role to a Waiver Case Manager and must be recognized as such by the MME Lead Case Manager.
- Under MFP's person-centered, individual choice approach, an individual may agree to undertake medical or other risks as long as he/she is fully informed of the risks and acknowledges the risks. I suggest that the MME protocol in such situations be the similar to the MFP protocol.
- One particular risk relates to nurse delegation of medical administration to a community person. In many circumstances, this delegation has reduced the cost of community LTSS significantly and enabled savings to be realized by a move to the community from an institution.
- The MFP quarterly reports, other evaluation documents, and experiences may be helpful to the MME program as it starts up.

Quincy

# Claudio Gualtieri AARP CT

Hi Kate, Sheila, and Olivia,

Thanks again for the opportunity to provide comment and feedback on the Draft Application. I appreciate your efforts to turn around application so quickly to give stakeholders an opportunity for review and comment prior to our meeting. Attached, please find AARP's comments on the March 19<sup>th</sup> Draft. Please feel free to contact me if you have any questions. I will see you all tomorrow afternoon for the Complex Care Committee Meeting, and look forward to the discussion.

Regards,  
Claudio

**Claudio W. Gualtieri | Associate State Director, Advocacy  
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To: Kate McEvoy, JD, Interim Director of the Division of Health Services, DSS  
From: AARP

**RE: Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees (3/19/13 Draft)**

AARP is pleased to have the opportunity to comment and share the following feedback on the Draft Application (State of Connecticut: Implementation of Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees, 3/19/13 Draft). Our comments include suggested improvements designed to protect beneficiary rights, support navigation of the appeals & grievance process, enhance consumer outreach & accessibility and ensure continuous consumer input in the Demonstration. Additionally, we have specific questions regarding the monthly process through which MME will have to change Lead Care Managers, opt-out of Model 2 and switch Health Neighborhoods. We believe safeguards must be specified to ensure that process provides an adequate time period each month for the MMEs to make changes and prevents any perverse incentive to steer the most vulnerable MMEs with high cost-care out of a particular Health Neighborhood or Model.

## **I. Oversight and Appeals**

Scope for Appeals: In order to best protect enrollees, ensure a focus on individual needs and enable analysis of systemic issues. AARP recommends that actions that can be appealed and warrant a hearing include instances when a person-centered plan is unacceptable to the enrollee. There should be a requirement to record and report on all grievance and appeals, or at the very least the portion of appeals in which a denial of coverage is eventually overturned and whether appeals assistance was provided to enrollees. We also recommend the creation of an oversight committee to review grievance and appeals data.

Ombudsman Services: On page 10 of the Draft Application (1.3.8 Integrated Grievance and Fair Hearing Process), the Department states that it is “considering employing an independent Ombudsman agency.” AARP strongly urges Connecticut to establish and fund independent ombudsman services to receive and respond to complaints, monitor resolution of complaints, monitor overall demonstration activity, and identify systemic problems in states’ dual demonstrations as part of the Demonstration. MMEs will need ready access to advocacy assistance. Ombudsman services will ensure that enrollees receive access to the full range of benefits and rights afforded by both Medicare and Medicaid initially and on an ongoing basis. Ensuring that benefits and rights are maintained and protected under Medicare, Medicaid, and state laws/regulations will require highly skilled, professional staff with sophisticated knowledge, medical and legal expertise.

Unified Grievance and Appeals Should Adopt Standards Most Favorable to MME: Where protections between Medicare, Medicaid, and state laws/regulations differ, the unified Grievance

and Appeal Process under development should include the terms and protections most favorable to the MME. The State must commit to assisting—preferably through the use of an independent ombudsman agency—Medicare/Medicaid enrollees in exercising grievance and appeal rights under Medicare and/or Medicaid. Grievance and appeal processes and timeframes should remain the same under the Demonstration as they currently exist under the Medicare and Medicaid programs.

## **II. Enrollment Services**

After-Hour Operation of Call Center: AARP supports a contract amendment with Xerox to require the operation of a call center (1.3.5 System and Member Enrollment-Xerox, Page 8). But, we would request that the contract requirement include a call center with extended evening hours and weekends to accommodate MMEs and their family/representatives that might not be available during normal business hours.

Moreover, the Draft application (Page 8), discusses the option to change HNs, Opt-out of Model 2, or change LCM on a monthly basis, but there is no specific time period within the month specified. At what point during the month and for how long will an MME have the option to make those changes? How will changes between neighborhoods, LCMs and different Models be reflected in data collection and quality measures?

## **III. Organizational Capacity**

Ongoing MME and Consumer Input: AARP recommends the inclusion of consumer and/or consumer representatives on the Steering Committee charged with directing development and implementation of the Demonstration. The current proposal, on page 13, only specifies representation from DSS, DMHAS, DDS and OPM. Consumer input is critical. In addition, other mechanisms such as focus groups, surveys, and attendance at community meetings should be used to ensure beneficiaries participating in the Demonstration can share their feedback and experience and help inform system improvements.

## **IV. Education and Outreach**

In addition to collaborating with community based organizations and advocacy groups, AARP recommends that the Department make a concerted effort to engage and include family caregivers as part of the public forums and Member Outreach discussed on Page 11 (1.3.11). Additionally, outreach materials should be accessible and understandable to beneficiaries, including individuals with disabilities and those with limited English proficiency, in accordance with Federal guidelines for Medicare and Medicaid. Materials should be translated into languages required under applicable Medicare and Medicaid rules, using the program standard that is more generous to beneficiaries. Where requested materials should also be available in alternative formats including large type font. The Department should consult with advocacy organizations on all materials that will be distributed to MMEs.

AARP supports the Department's commitment to educate/inform MMEs about options to accept or decline enrollment, conditions for their approval to share health information, beneficiary protections and process for filing Grievance and Appeals. However, we would suggest that the Department hire independent parties skilled in communications and knowledgeable about health care delivery to conduct these meetings. We would further recommend that Member Outreach include information explaining that:

- Full Medicare and Medicaid benefits will remain unchanged
- Assurances that beneficiaries will maintain their choice of providers
- A description of new benefits and services provided under the Demonstration
- A listing of resources for the beneficiary to obtain additional information on the Demonstration
- The date the Demonstration will begin

## **V. Evaluation and Report**

Data Collection to Measure Racial and Ethnic Disparity: One issue that was not raised in Draft application was the issue of measuring for racial disparities. AARP recommends including language under the Evaluation and Reporting section (page 13), which was included in the Washington State MOU, requiring HN performance results to be stratified by race, ethnicity, age, language, disability status, and gender. We encourage the use of direct feedback from individuals and their families through consumer experience surveys and consumer-reported outcomes on functional status, complications, pain, etc.

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# Jill Benson LCSW CHR Health

Good morning,

Thanks for the opportunity to comment on this. Overall think you did a good job in answering the questions. I especially like the swipe card idea and the provider portal containing claims information, assessments and plans of care.

The attached has my comments as well as comments from other CHR colleagues- I went through it in order and commented as well as asked clarifying questions. Some of it is not clear to me, and I figured if I, who have been part of these detailed discussions, didn't understand it, then maybe it was not clear to a less involved reader. ( On the other hand, I am always trying to get to the practical, operational details and implications which may influence my line of questions- important issues to consider, but maybe not needed for the application)

See you tomorrow.

Jill

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Highlighted words are suggestions to add to language in the document

- In the introduction, it might be useful to tie the last paragraph on first page to the triple aim. (better outcomes, better health, greater efficiency)
- Care coordination: ...assessment-based interdisciplinary approach to integrating healthcare, **behavioral health** and social supports...( to make sure this is not forgotten)
- Not clear if assessment is part of the Targeted Outreach level of Care Coordination
- Person centered care, last bullet regarding integrated setting – should allow for that to be virtual as well as within a particular setting

## **Model 1- Enhanced ASO**

The **medical** ASO (CHN) will provide the modeling for the enrollment into the HN's using the waterfall rules of assignment to an HN if the MME has received primary care from a provider in a HN first, or no primary care, but behavioral health care from a HN provider, second. Will CHN have access to the behavioral health claims to make that assignment for the second situation ? It is important for that data to be available to whoever is making the assignments since many of the MME's with Serious mental health diagnosis, will not have seen a primary care physician during the past year. You may have accounted for this but it's not clear in this response.

Also, in this section the role of Value Options, in this effort is not clearly articulated.

**Regarding the APM2-** it's not clear how this will work.( These questions may not be required to be answered for the application )

- Do the administrative and startup funds for the Administrative Lead come out of this off the top?
- If the LCM gets a risk adjusted payment – what is the timing of this?

- Does the MME have to be assessed and put into a level of care coordination before this risk adjustment can be made?
- If the risk adjustment is based on past claims data, remember that many MME's with behavioral health have had limited use of primary care services, so may be underrepresented.
  - Does the LCM APM2 payment have to also pay for the supplemental services, or will that be paid for separately and by which entity, ALA, LCM or DSS/HP? Will there be a proposed budget for these services?

#### **Data analysis and rate setting**

- Data CHN will use to provide predictive modeling in identifying the formulation of Plans of Care- I thought this was to be with the MME and their selected LCM and based on an assessment.

#### **Evaluation and reporting**

- Since 38% of the population have SPMI, if the UConn Center on Ageing is the evaluator , it will be important for them to partner with an entity with expertise in the SPMI population(UConn Dept. of Psychiatry?)

#### **General comments:**

- DSS will be using many contractors to perform the various admin. functions for data analysis, rate setting, evaluation, enrollment ,etc.-  
A \$1m investment in these back office functions seems steep, particularly if you consider the low number of overall individuals who will participate with health neighborhoods. Additionally, there seems to be lots of overlap in functions across the proposed vendors (HP, Xerox, CHNCT, HNs) as related to system and membership enrollment.
- From a quality of care, cost and research perspective, how does the ability for MME's to opt out on a monthly basis, influence the outcomes that can be achieved by the HN? (I realize MME's choice needs to be protected)
- How does enrollment and enrollment broker tie into the Healthcare Exchange?

# Matt Katz CSMS

Kate, Sheila and Olivia,

First, I appreciated the opportunity to talk today and discuss the proposal as part of the CCC executive committee. What follows are those points I made during the call today and then some other more minor comments or suggestions for revisions to the proposal.

## 1. Definitions

- a. Lead Care Manager- provide a greater level of specificity as to this individual or entities role within the definition of the Lead Care Manager, making sure it comports to what is then suggested of the role of the Lead Care Manager within the Care Management definition and other areas throughout the proposal. Also, specifically determining or referencing if the Lead Care Manager is an individual or entity/agency from the standpoint of the care provision and coordination referenced.
- b. Targeted Outreach- is this the area where a discussion of the provision of health information for patients, their families and advocates should go? Also, though health information is a critical, another area of what I thought we wanted to highlight in outreach to patients was health equity (cultural competency) and the proposal appears to be devoid of this.
- c. Administrative Lead Agency- referenced but not defined (roles and responsibilities)
- d. Lead Care Management Agency- referenced but not defined (roles and responsibilities)

## 2. Health Neighborhoods

- a. Providing a bit more specificity as to how the number and geographic area of the health neighborhood may have an impact on the budget (I am to understand that the budget document will have some reference to this).
- b. Some more specificity as to what is meant by geographic area within the context of the Health Neighborhood (are we talking about concentric circles, could the area be across various MSAs/pieces of MSAs, etc). What constitutes a geographic area?
- c. What is meant by critical mass within this context (number of eligible MMEs or actual MMEs within the HN)?

## 3. Process Measures

- a. Making it clear that patient rights advocates and physicians and others who are providing medical and social services are involved and engaged in the process of measurement development, determination and evaluation for the Neighborhoods (performance measures). From a physician perspective, it should be practicing physicians who are engaged or going to be engaged in the neighborhood structure and will be providing the care modalities required to meet the requirements of a Neighborhood.
- b. Some of the state specific measures suggested overlap with the other identified measures/benchmarks and potential measure sets. It would be important to have a close review of what each measure set is intended to measure and if there are both gaps and overlaps before determining which one or ones to utilize and these measure sets should be tested with practicing physicians and other care providers prior to a final decision.

## 4. Health Neighborhood Formation and Start Up

- a. As discussed, it may not be wise to reference entities who are not contracted with the state tied to particular services as potentially providing these services, especially when the services are not yet well defined.

- b. Also, from a specific development structure, the entity or entities helping with neighborhood formulation tied to connectivity between providers may not be the same entity or entities that are helping with the “legal requirements” for the neighborhood. Care provision connections such as patient centered medical home parameters and connectivity, is very different than the legal structures required for contracting. Data integrity and integration may also be different and therefore may require a different entity or agency to assist.
  - c. Network agreements are also a very different issue than network connectivity and data usage agreements and may require different levels of assistance provided by different entities.
  - d. Please note that there is a grammatical error in that “connective” should likely be “connectivity” within this section
5. Other Areas of Question and Comment
- a. From a claims perspective, if any changes in how claims are going to be processed within a physicians practice will need to be discussed, it would be beneficial to have physicians and/or their clinical coders/billers involved in these discussions. Are we talking about different reporting requirements? Again, this should involve those presenting preparing the CMS 1500 forms and related documentation and reporting to be involved.
  - b. Back to the issue of area and crucial mass for a HN, it is strongly suggested and encouraged that in order to have a sufficient pilot experience that at least one rural HN is selected or allowed to determine if this model of care and care management and coordination can work in both urban and rural settings within Connecticut. There are a number of social and service issues that may be reflective of geography within Connecticut that will need to be explored during the pilot phase and having a variety of location dynamics for testing will be critical. Connecticut does not have very large cities compared to other states where there are large clusters of patients and tends to have smaller cities, towns and communities and care often extends across and among these often geographically disconnected areas (in part because of transportation barriers or opportunities) and when looking at determining potential HN pilot locations all of this needs to be considered.

Thank you for the opportunity to provide comment in preparation for tomorrow's CCC meeting and thank you again for listening to most of these questions and comments this morning during the CCC executive committee conference call.

Matt

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# Molly Rees Gavin CT Community Care

From: [mollyreesgavin@aol.com](mailto:mollyreesgavin@aol.com) [mollyreesgavin@aol.com]

Sent: Wednesday, March 20, 2013 10:59 PM

To: McEvoy, Kate

Cc: [sheilabamdur@gmail.com](mailto:sheilabamdur@gmail.com); [olivia.puckett@cga.ct.gov](mailto:olivia.puckett@cga.ct.gov); [MollyG@ctcommunitycare.org](mailto:MollyG@ctcommunitycare.org); [mollyreesgavin@aol.com](mailto:mollyreesgavin@aol.com)

Subject: Comments from Molly Rees Gavin

Hi Kate; Sheila and Olivia:

As Kate knows, I am on vacation in Key West with my family and will do my best to provide some reflections on the draft. It is absolutely fine with me if you choose not to share all my comments with the entire committee. I am not using my own computer and must apologize in advance for typos, etc.

I think that the overall proposal lacks clarity in terms of what the perceived benefits are for the individuals and for the "system." The actual writing isn't up to the standard of writing I have seen thus far from the Department on this issue; it almost sounded as if it was written by "another voice" entirely.

The role of CHNCT regarding care management isn't entirely clear (in contrast to the HN care management) but that may be too much detail for this level of submission. I just have to say that I still find it confusing after all these months.

It is not clear how DSS arrived at the \$250K as the "magic number" for the up front payment to the HN. It seems very low to me and I would hate to see you get locked into it this early on in the process if that is not necessary.

I applaud the section on beneficiary protections; particularly the reference to freedom of choice of providers. I have seen this "right" insidiously eroding for MMEs and for others with the dramatic increase in mergers, acquisitions, etc. in the health care arena.

One tiny edit; the words "senior citizens" are used toward the end of the document. Older adults/elders might be more appropriate.

I have asked my colleague Sherry Ostrout to attend this Friday's meeting on my behalf. I have immediate access to my aol account so feel free to contact me with any questions or concerns.

Thank you all for the extraordinary work on this initiative.

# Marie Smith UConn School of Pharmacy

Hi Sheila, Kate, and Olivia....thanks for the opportunity to comment on materials for the April 1 application. I've attached some comments/questions within the "Questions for Connecticut about the Standards & Conditions for its Proposed Managed Fee-For-Service Financial Alignment Demonstration" that can be addressed to strengthen the final application and future HN documents.

I will be happy to address any clarifications or questions you may have and plan to attend the March 22 Complex Care Committee meeting.

Regards,  
Marie

Marie Smith, PharmD  
Henry A Palmer Professor in Community Pharmacy Practice Asst. Dean, Practice and Public Policy Partnerships UConn School of Pharmacy - Storrs, CT

## Please see PDF in separate attachment.

# Olivia Puckett- CGA

Hi All,

Just a quick note:

On Page 12: There is mention to the Health Information Exchange (HIX)

On Page 13: There is mention to the CT Health Information Exchange (HIE)

Not sure if the acronyms are supposed to be the same or different.

On Page 9: 1.3.7 CMS Authorities “ Savings off”

Not sure if it’s supposed to be of or off

I hope this is helpful. Very impressive and clear application.

Thank you.

**Warmest regards,**

**Olivia Puckett**

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# Steering Committee: Complex Care Committee

## **CCC Steering Committee--**

Kate McEvoy, Rivka Weiser, Jen Hutchinson, Matt Katz, Quincy Abbott, Sheldon Toubman, Ellen Andrews, Sheila Amdur

1. Sheila raised issues re state agency as BHP--contracting , accountability, is DMHAS part of RFP process (developing RFP), will state agency be designated as BHP without competition, does Admin Lead have separate contract with BHP (including state agency) that sets out requirements for performance and termination of contract? DMHAS has specified that they will not be accepting any APMII or shared savings. Role of Leads will be in application. Kate said RFP process will treat all applicants competitively with same process for evaluation. No interested party can serve in that process. Kate said this needs to be incorporated in Operating Plan to be submitted with document.

2. Financial model--Matt Katz asked if financial model will be based on naturally occurring clusters and acuity within those clusters. Mercer is using an index re acuity re Medicare/Medicaid population across the whole population and not in particular geographical areas. There will be on financial model with advance payment uniform across all Neighborhoods and then tailored Lead Care Management payment based on acuity.

Kate McEvoy--Mercer hasn't completed analysis of financial data. David Parrella will be submitting more information on financial model--on acuity levels, range of APMII. Information in budget for April 1 will be on implementation funds needed going forward. Ellen raised concerns about Mercer's past performance and assurances re transparency and input re how this has been done--actuarial method, process of fleshing out financial model still in process. At April meeting, invite if they are available Mercer to present.

3. Sheldon commented that introduction good, but still omits issue of underutilization. Kate said that this can be added.

4. Quincy suggested that "Targeted Outreach" be specific about coordinating with other federal waivers and grants. Quincy added that it was implied that LCM cannot "override" waiver manager. Kate said more detail that there is more detail in Care Coordination document. LCM



will coordinate all information, but Waiver manager, MFP manager, and LMHA case manager would have to be part of care management team. LCM does not control waiver funds or control any other resources except supplemental services.

5. Matt asked where health information for MMEs is highlighted and achieving health equity for them. Care Management talks about what services that have to be provided but is not specific, particularly re Lead Care Manager. Is LCM an entity or an individual? Kate will clarify. Also Care Management document will be addendum to application. Admin Lead Agency referenced throughout but it is not defined in scope and duties. HN Operating Plan will also be addendum to document.

6. Matt noted that References to "contracting agencies" throughout document, but state has no contracts yet. Qualidigm specifically referenced. Kate noted that some groups state already has contracts.

7. Ellen asked about privacy issues and "informed consent", which is not defined.

8. Sheldon asked about evaluation re supplemental services and whether they should be extended to whole population. Also whether Model 1 should be expanded to other states, not just Model 2. Other fee for services would not necessarily regard this as new model since many are using Model 1.

9. Matt asked that providers would be involved in developing measurement criteria (patient rights advocates, physicians).

REVISED DRAFT WILL BE SUBMITTED BY TUESDAY, March 26. CCC members will be asked to quickly review and comment for presentation to Medicaid Oversight Council Executive Committee.

10. Incorporate comments from others: Marie Smith, Molly Gavin, Bob Smanek.

# Sheldon Toubman- New Haven Legal Assistance

**From:** Sheldon Toubman [<mailto:SToubman@nhlegal.org>]

I will give you all some minor typographical corrections tomorrow, but the major changes to the proposed CMS document that I think are needed are these:

1. On page 1, the last paragraph on section 1.1 should have added, after the words “over-treatment and/or duplication...”: “and addressing areas of inadequate care,”  
The need for this change is self-evident.
2. On page 9, the “Appeals” section of section 1.3.8 should be revised to make clear it applies to “denials, **partial denials**, **terminations**, **suspensions** or reductions in service...”  
This is what is required by existing federal Medicaid regulations.
3. On page 10, top of the page, the statement in section 1.3.8 that “the Department is also considering employing an independent Ombudsman agency” should be changed to “the Department **will be** employing an independent Ombudsman agency.” There is really no justification NOT to do this, especially given the extreme vulnerability of this population. Other states are doing this. And, while it does not have to be done in this particular manner, we already have infrastructure to do this through the Office of the Healthcare Advocate; they would need some modest additional funding to take on this responsibility, of course. But one thing is clear: the ombudsman must be independent of DSS, CHNCT and providers.
4. On page 11, the basic program evaluation goals in section 1.3.11 are highly one-sided in that they don’t allow for the possibility that the evaluation would result in a conclusion that **model #1** is actually as good or better and should be used universally in CT and replicated in other states. So I would revise #3 in section 1.3.11 to say “3) identify factors that support success and determine the means by which the Health Neighborhood model **and/or the ASO model** can be expanded within Connecticut or other states.”
5. Later on page 11, where it identifies specific things the evaluator will be looking at, a critical thing missing is looking at the effectiveness of the supplemental services in model #2 and whether they are demonstrated to be of sufficient value that all duals or maybe all ABD enrollees in Medicaid should receive them. So I would add a fifth item: “and analyze data regarding supplemental services to assess their effectiveness and their potential expansion to the larger MME and Medicaid populations.”

Thank you for noting these substantive proposed revisions.  
Sheldon

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Thanks very much, Kate and Rivka. I am very sorry for the error in the submission of my comments. Yes, I want these to be part of the compilation.

There is also a 6<sup>th</sup> point, following what AARP has submitted:

6. There should be consumer and/or consumer representatives on the Steering Committee charged with directing development and implementation of the Demonstration. The current proposal, on page 13, only specifies representation from DSS, DMHAS, DDS and OPM. Consumer input is critical. In addition, other mechanisms such as focus groups, surveys, and attendance at community meetings should be used to ensure beneficiaries participating in the Demonstration can share their feedback and experience and help inform system improvements.

Sheldon

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